

		FOR OFF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019364

Facility Name: Central Nursing

Address: 2450 North Central Ave Chicago 60639
Number City Zip Code

County: Cook

Telephone Number: (773) 889-1333 Fax # (773) 889-1516

IDPA ID Number: 362801271001

Date of Initial License for Current Owners: 01/01/1973

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
X "Sub-S" Corp.
Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Sanford Alper Telephone Number: (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)		
	(Title)		
Paid Preparer	(Signed)		
	(Print Name and Title)	Sanford Alper - Principal	
	(Firm Name & Address)	Kessler, Orlean, Silver & Company, P.C. 1101 Lake Cook Road Suite C Deerfield, IL 60015-5233	
	(Telephone)	(847) 580-4100 Fax # (847) 580-4199	
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Central Nursing

0019364 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

245

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>245</u>	Skilled (SNF)	<u>245</u>	<u>89,425</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>245</u>	TOTALS	<u>245</u>	<u>89,425</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>75,449</u>	<u>3,922</u>	<u>6,582</u>	<u>85,953</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>75,449</u>	<u>3,922</u>	<u>6,582</u>	<u>85,953</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.12%

D. How many bed-hold days during this year were paid by Public Aid? 2,175 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 01/01/1973

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 22 and days of care provided 116

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	186,811	41,591	11,981	240,383		240,383		240,383			1
2	Food Purchase		185,901		185,901	(43,654)	142,247	(106)	142,141			2
3	Housekeeping	150,288	10,133	11,779	172,200		172,200		172,200			3
4	Laundry		10,322		10,322		10,322		10,322			4
5	Heat and Other Utilities			169,107	169,107		169,107		169,107			5
6	Maintenance	31,016		19,123	50,139		50,139		50,139			6
7	Other (specify):*											7
8	TOTAL General Services	368,115	247,947	211,990	828,052	(43,654)	784,398	(106)	784,292			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,491,293	79,328	980	1,571,601		1,571,601		1,571,601			10
10a	Therapy	83,597		3,266	86,863		86,863		86,863			10a
11	Activities	59,036	1,140		60,176		60,176		60,176			11
12	Social Services	14,381		4,140	18,521		18,521		18,521			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*			690	690		690		690			15
16	TOTAL Health Care and Programs	1,648,307	80,468	9,076	1,737,851		1,737,851		1,737,851			16
	C. General Administration											
17	Administrative	137,704		417,929	555,633		555,633	(417,929)	137,704			17
18	Directors Fees											18
19	Professional Services			31,030	31,030		31,030	178	31,208			19
20	Dues, Fees, Subscriptions & Promotions			40,854	40,854		40,854	13	40,867			20
21	Clerical & General Office Expenses	145,918	11,641	9,053	166,612		166,612	2,095	168,707			21
22	Employee Benefits & Payroll Taxes			312,157	312,157	43,654	355,811	15,086	370,897			22
23	Inservice Training & Education											23
24	Travel and Seminar			960	960		960		960			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			180,365	180,365		180,365		180,365			26
27	Other (specify):*											27
28	TOTAL General Administration	283,622	11,641	992,348	1,287,611	43,654	1,331,265	(400,557)	930,708			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,300,044	340,056	1,213,414	3,853,514		3,853,514	(400,663)	3,452,851			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			30,771	30,771		30,771	89,060	119,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			336	336		336	(336)				32
33	Real Estate Taxes			216,372	216,372		216,372		216,372			33
34	Rent-Facility & Grounds			1,176,327	1,176,327		1,176,327	(1,176,327)				34
35	Rent-Equipment & Vehicles			17,503	17,503		17,503		17,503			35
36	Other (specify):*											36
37	TOTAL Ownership			1,441,309	1,441,309		1,441,309	(1,087,603)	353,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		101,978		101,978		101,978		101,978			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			143,955	143,955		143,955		143,955			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		101,978	143,955	245,933		245,933		245,933			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,300,044	442,034	2,798,678	5,540,756		5,540,756	(1,488,266)	4,052,490			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	31,421	30		9
10	Interest and Other Investment Income	(336)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(106)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(392)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(50)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 30,537		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,518,803)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,518,803)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,488,266)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Central Nursing

ID#

0019364

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Franchise Tax	\$ (50)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(50)		49

Summary A

12/31/2001

[illegible]

Summary B

12/31/2001

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago	Nivram	Chicago	Nursing Home
Joseph Mermelstein	50.00%	Emerald Park Nursing Center	Evergreen Park	Management, Inc.		Management
		Balmoral Home	Chicago			
		Sovereign Healthcare, LLC	Chicago			
		Chicago Ridge Nursing Center	Chicago Ridge			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	\$	Nivram Management, Inc.	50.00%	\$ 121	\$ 121	1
2	V	21	Office Expense		Nivram Management, Inc.	50.00%	213	213	2
3	V	21	Supplies		Nivram Management, Inc.	50.00%	1,549	1,549	3
4	V	20	Franchise Tax		Nivram Management, Inc.	50.00%	13	13	4
5	V	19	Accounting		Nivram Management, Inc.	50.00%	178	178	5
6	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	15,086	15,086	6
7	V	21	Telephone		Nivram Management, Inc.	50.00%	654	654	7
8	V	34	Rent	1,176,327	Henry Mermelstein	0.00%		(1,176,327)	8
9	V	30	Depreciation		Henry Mermelstein	0.00%	57,639	57,639	9
10	V	17	Administrative	417,929				(417,929)	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,594,256			\$ 75,453	\$ * (1,518,803)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrator	Administrative	None	168,795	20	24.98	Salary	\$ 56,205	L17, Col 1	1
2	Louise Mermelstein	Dietary Supervisor	Support	None	48,800	31	39.00	Salary	31,200	L1, Col 1	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	38,598	4	24.98	Salary	12,852	L6, Col 1	3
4	Doreen Mermelstein	Administrative Asst.	Clerical	None	71,269	15	24.98	Salary	23,731	L21, Col 1	4
5	Marvin Mermelstein	Asst. Administrator	Administrative	See Above	145,201	7	24.98	Salary	48,349	L17, Col 1	5
6	Joseph Mermelstein	Owner	Administrative	50.00%	51,850	5	39.00	Salary	33,150	L21, Col 1	6
7											7
8											8
9			See Attached Schedule								9
10											10
11											11
12											12
13								TOTAL	\$ 205,487		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Central Nursing # 0019364 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Nivram Management, Inc.
Street Address 2155 West Pierce
City / State / Zip Code Chicago, IL 60622
Phone Number (773) 252-3208
Fax Number (773) 252-3688

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		Bank Charges	Resident Beds	980	6	\$ 485	\$	245	\$ 121	1
2		Office Expenses	Resident Beds	980	6	851		245	213	2
3		Supplies	Resident Beds	980	6	6,194		245	1,549	3
4		Franchise Tax	Resident Beds	980	6	50		245	13	4
5		Accounting	Resident Beds	980	6	713		245	178	5
6		Payroll Taxes	Resident Beds	980	6	60,345		245	15,086	6
7		Telephone	Resident Beds	980	6	2,615		245	654	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 71,253	\$		\$ 17,814	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	Misc. Interest Expense											336	10
11	Non - Allowable Amount											(336)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Central Nursing

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0019364

CONTACT PERSON REGARDING THIS REPORT

Sanford Alper

TELEPHONE (847) 580-4100

FAX #: (847) 580-4199

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>13-29-431-013-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 11,208.72</u>	<u>\$ 11,208.72</u>
2.	<u>13-29-431-014-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 27,085.11</u>	<u>\$ 27,085.11</u>
3.	<u>13-29-431-015-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 27,085.10</u>	<u>\$ 27,085.10</u>
4.	<u>13-29-431-016-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 27,085.11</u>	<u>\$ 27,085.11</u>
5.	<u>13-29-431-017-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 27,085.11</u>	<u>\$ 27,085.11</u>
6.	<u>13-29-431-018-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 27,085.11</u>	<u>\$ 27,085.11</u>
7.	<u>13-29-431-019-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 27,085.11</u>	<u>\$ 27,085.11</u>
8.	<u>13-49-431-020-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 21,587.56</u>	<u>\$ 21,587.56</u>
9.	<u>13-29-431-021-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 1,536.88</u>	<u>\$ 1,536.88</u>
10.	<u>13-29-431-022-0000</u>	<u>2450 N. Central Avenue</u>	<u>\$ 1,627.77</u>	<u>\$ 1,627.77</u>
		TOTALS	<u>\$ 198,471.58</u>	<u>\$ 198,471.58</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 67,185

B. General Construction Type: Exterior BrickFrame SteelNumber of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	30,000	1973	\$ 158,977	1
2					2
3	TOTALS	30,000		\$ 158,977	3

Facility Name & ID Number Central Nursing

0019364

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	245		1973	1973	\$ 1,729,156	\$	30	\$ 57,639	\$ 57,639	\$ 1,637,475	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler System			1976	8,246		20			8,246	9
10	Hot Water Heater			1983	2,156		10			2,156	10
11	Light Fixtures			1984	14,684		10			14,684	11
12	Roof			1984	20,000	1,053	20	1,000	(53)	17,417	12
13	Heating & Air Conditioning			1983	2,924		20	146	146	2,579	13
14	Painting & Decorating			1983	7,863		8			7,863	14
15	Doorways			1986	1,840	97	15	68	(29)	1,840	15
16	Elevator Upgrade			1986	1,080	57	20	54	(3)	795	16
17	Wall Corner Guard			1987	1,531	49	10		(49)	1,531	17
18	Resurface Parking Lot			1987	6,900	219	15	460	241	6,583	18
19	Additions			1988	1,200	38	20	60	22	768	19
20	Heater Foundation			1989	1,000	32	20	50	18	590	20
21	Roof			1990	7,916	251	20	396	145	4,441	21
22	Roof			1990	2,199	70	8		(70)	2,199	22
23	Various Improvements			1990	1,850		8			1,850	23
24	Cubicle Curtains			1992	11,273	358	10	1,127	769	10,592	24
25	HVAC Improvements			1993	8,907		10	892	892	7,730	25
26	Draperies			1993	2,700		10	270	270	2,340	26
27	Tiling			1995	6,600	169	10	660	491	4,400	27
28	Leasehold Improvements			1995	15,914		10	1,591	1,591	10,607	28
29	Generator			1996	17,527	449	10	1,753	1,304	9,933	29
30	Roof			1996	4,800	123	10	480	357	2,720	30
31	Door			1997	2,465	63	10	247	184	1,152	31
32	Wiring for Emergency System			1997	5,000	128	10	500	372	2,333	32
33	Phone System			1997	8,238		10	823	823	3,841	33
34	Architecture			1998	6,000	154	10	600	446	2,200	34
35	Boiler, A/C, Ductwork			1998	16,664	427	10	1,666	1,239	6,109	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Roofing	1998	\$ 54,000	\$ 1,385	10	\$ 5,400	\$ 4,015	\$ 19,800	37
38	Parking Lot Improvements	1998	8,000		10	800	800	2,133	38
39	Elevator Improvements	1998	4,450	68	10	445	377	1,187	39
40	HVAC Improvements	1998	2,820	72	10	282	210	752	40
41	Fire Alarm System & Doors	1999	107,500	2,756	10	10,750	7,994	28,667	41
42	Extended Walls Through Ceiling	1999	3,000	77	10	300	223	800	42
43	Elevator Improvements	1999	2,650	68	10	266	198	709	43
44	HVAC Improvements	1999	20,388	523	10	2,038	1,515	5,435	44
45	Landscape Work	1999	4,100	105	10	410	305	1,093	45
46	Elevator Improvements	2000	89,750	288	10	8,975	8,687	14,959	46
47	HVAC Improvements	2000	23,639	177	10	2,364	2,187	3,940	47
48	Telephone System	2000	7,500	120	10	750	630	1,250	48
49	Air Conditioning System	2001	4,000	103	10	400	297	400	49
50	Air Conditioning System	2001	10,800	196	10	765	569	765	50
51	Air Conditioning System	2001	2,500	32	10	125	93	125	51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,261,730	\$ 9,707		\$ 104,552	\$ 94,845	\$ 1,856,990	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$86,153	\$12,537	\$9,283	\$(3,254)	8-10 Year	\$	71
72	Current Year Purchases	9,136	1,413	441	(972)	10 Years	441	72
73	Fully Depreciated Assets	334,931				5-10 Year	334,931	73
74								74
75	TOTALS	\$430,220	\$13,950	\$9,724	\$(4,226)		\$335,372	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Facility Storage	Storage Trailer	1986	\$900	\$	\$	\$	4	\$900
77	Administrative	1986 Chrysler	1986	16,095				4	16,095
78	Administrative	1987 Chevy	1987	12,510				4	12,510
79	See Attached Schedule A			41,059	7,114	5,555	(1,559)		30,333
80	TOTALS			\$70,564	\$7,114	\$5,555	\$(1,559)		\$59,838

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	2,921,491
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	30,771
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	119,831
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	89,060
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,252,200

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☒ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
☐ YES☒ NO
16. Rental Amount for movable equipment: \$17,503Description: Ice Maker \$900 Copier \$1,727 Mattresses \$14,876
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	L 15 Col 3	12 visits	690				12	690	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39 Col 2	# of prescrpts				7,548		7,548	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Enteral Tube Feeding	L 39 Col 2					94,430		94,430	13
14	TOTAL			\$ 690		\$	\$ 101,978	12	\$ 102,668	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number	Central Nursing
---------------------------	-----------------

0019364

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 413,844	\$ 413,844	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,006,116	1,006,116	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,318	45,318	6
7	Other Prepaid Expenses	209,221	209,221	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,674,499	\$ 1,674,499	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,977	13
14	Buildings, at Historical Cost		1,729,156	14
15	Leasehold Improvements, at Historical Cost	446,792	505,922	15
16	Equipment, at Historical Cost	302,588	529,317	16
17	Accumulated Depreciation (book methods)	(317,937)	(2,175,424)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	500,100	500,100	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 931,543	\$ 1,248,048	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,606,042	\$ 2,922,547	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 21,010	\$ 21,010	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	204,500	204,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Rent</u>	703,687	703,687	36
37		252,574	252,574	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,181,771	\$ 1,181,771	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,181,771	\$ 1,181,771	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,424,271	\$ 1,740,776	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,606,042	\$ 2,922,547	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,227,033	1
2	Restatements (describe):		2
3	Change in Equity during interim period 11/1/00 - 12/31/00	257,112	3
4	Facility changed from fiscal year ending Oct. 31 to		4
5	calendar reporting year ending December 31.		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,484,145	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,590,126	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(3,650,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (59,874)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,424,271	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	1
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 9,050,480	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,050,480	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	22,137	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 22,137	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46,956	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,956	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending</u>	6,505	28
28a	<u>Miscellaneous</u>	3,580	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10,085	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,129,658	30

	Expenses	Amount	2
	A. Operating Expenses		
31	General Services	828,052	31
32	Health Care	1,737,851	32
33	General Administration	1,287,611	33
	B. Capital Expense		
34	Ownership	1,441,309	34
	C. Ancillary Expense		
35	Special Cost Centers	101,978	35
36	Provider Participation Fee	143,955	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,540,756	40
41	Income before Income Taxes (line 30 minus line 40)**	3,588,902	41
42	Income Taxes	1,224	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,590,126	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,254	2,446	\$ 69,452	\$ 28.39	1
2	Assistant Director of Nursing	2,113	2,316	52,540	22.69	2
3	Registered Nurses	34,451	36,518	658,062	18.02	3
4	Licensed Practical Nurses	6,735	7,197	105,880	14.71	4
5	Nurse Aides & Orderlies	74,770	80,210	605,359	7.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,514	4,712	83,597	17.74	8
9	Activity Director	1,358	1,390	13,382	9.63	9
10	Activity Assistants	7,385	7,640	45,654	5.98	10
11	Social Service Workers	1,909	2,069	14,381	6.95	11
12	Dietician	1,975	2,175	26,185	12.04	12
13	Food Service Supervisor					13
14	Head Cook	3,077	3,317	33,351	10.05	14
15	Cook Helpers/Assistants	15,603	16,667	127,275	7.64	15
16	Dishwashers					16
17	Maintenance Workers	2,090	2,250	31,016	13.78	17
18	Housekeepers	18,168	19,412	150,288	7.74	18
19	Laundry					19
20	Administrator	1,283	1,283	89,355	69.65	20
21	Assistant Administrator	351	351	48,349	137.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,623	8,213	145,918	17.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	185,659	198,166	\$ 2,300,044 *	\$ 11.61	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 11,981	L1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	980	L 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	71	3,266	L 10A Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	113	4,140	L 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	184	\$ 20,367		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

STATE OF ILLINOIS

Facility Name & ID NumberCentral Nursing# 0019364Report Period Beginning:01/01/2001Ending:12/31/2001Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Henry Mermelstein	Administrator	0.00	\$ 56,205
Marvin Mermelstein	Asst. Admin.	50.00	48,349
Joseph Mermelstein	Administrator	50.00	33,150
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,704

B. Administrative - Other

Description	Amount
	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Orlean, Silver & Co.	Accounting	\$ 10,500
Richard Peelo	Medicare Consulting	4,550
N.H.P.S. Personnel	Employee Recruitment	4,710
Immigration & Naturalization	Registration Service	575
Personnel Planners, Inc.	U/C Consultant	973
System Management	Billing Consulting	5,121
Medi.com	Computer Support	259
Health Data Systems	Computer Support	2,322
Accu-Med Services	Computer Support	2,020
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 31,030

D. Employee Benefits and Payroll Taxes

Description	Amount	
Workers' Compensation Insurance	\$ 24,736	
Unemployment Compensation Insurance	12,331	
FICA Taxes	155,171	
Employee Health Insurance	99,405	
Employee Meals	43,654	
Illinois Municipal Retirement Fund (IMRF)*		
Chicago Head Tax	3,960	
Other Employee Benefits	16,554	
Allocation from Management	15,086	
TOTAL (agree to Schedule V, line 22, col.8)		\$ 370,897

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount	
IDPH License Fee	\$	
Advertising: Employee Recruitment	25,010	
Health Care Worker Background Check (Indicate # of checks performed)		
Illinois Council on Long Term Care	11,454	
Licenses & Permits - see Attached Sch A	4,390	
Allocate from Management Co.	13	
Less: Public Relations Expense	()	
Non-allowable advertising	()	
Yellow page advertising	()	
TOTAL (agree to Sch. V, line 20, col. 8)		\$ 40,867

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	960
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 960

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long term Care \$11,454
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,368 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 143,955
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 43,654 Has any meal income been offset against related costs? NO Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Adequate records are maintained
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees